No. 87-850

Supreme Court, U.S.
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In The
Supreme Court of the United States
October Term, 1987

HART SCHAFFNER & MARX and HART SCHAFFNER & MARX SUBSIDIARY AND AFFILIATED COMPANIES GROUP LIFE INSURANCE AND MEDICAL PLAN,
Petitioners,

v.

BARBARA AND CHRISTOPHER SCHULTZ, individually and on behalf of their minor daughter, RACHAEL SCHULTZ,
Respondents.

On Writ Of Certiorari To
The United States Court Of
Appeals For The Fifth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Section 503 of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1133 ("ERISA"), requires that every employee benefit plan provide an internal administrative appeal procedure to establish review by the plan fiduciary in the event of a claim denial. The doctrine of exhaustion is judicially incorporated into ERISA cases involving a denial of benefits, requiring a claimant to conclude administrative remedies before prosecuting a federal lawsuit.

. . . .

Whether the exhaustion doctrine is defeated by the Court of Appeals' vacation of the District Court's dismissal for failure to conclude administrative review before suit.

PARTIES TO THE PROCEEDINGS

Respondents filed their Amended Complaint in the United States District Court for the Eastern District of Louisiana against three defendants: Metropolitan Life Insurance Company ("Metropolitan"); Hart Schaffner & Marx ("HSM") and Hart Schaffner & Marx Subsidiary and Affiliated Companies Group Life Insurance and Medical Plan ("the Plan"). Metropolitan was dismissed from the case with prejudice during the pendency of the appeal before the United States Court of Appeals for the Fifth Circuit. Thus, only HSM and the Plan are Petitioners in the proceedings before this Court.

Petitioner HSM is a wholly-owned subsidiary of Hartmarx Corporation. HSM is a New York corporation with numerous wholly-owned subsidiaries. In addition, HSM owns a 96 percent interest in Thorngate S.A. de C.V. HSM has numerous affiliates by virtue of

their common ownership by Hartmarx Corporation. Three such affiliates are not wholly-owned subsidiaries of Hartmarx Corporation:

(1) Country Miss, Inc., in which Hartmarx owns a 92 percent interest; (2) Organizacion Robert's S.A. de C.V., in which Hartmarx Corporation owns a minority interest; and (3) Austin Reed Group Limited in which HSM owns a minority interest.

TABLE OF CONTENTS

	Page
QUESTIONS PRESENTED	i
PARTIES TO THE PROCEEDINGS	ii
TABLE OF CONTENTS	iv
TABLE OF AUTHORITIES	v
OPINIONS BELOW	1
JURISDICTION	2
STATUTES INVOLVED	2
STATEMENT OF THE CASE	2
REASONS FOR GRANTING THE WRIT	7
CONCLUSION	15

APPENDICES:

A. Fifth Circuit July 22, 1987 order vacating dismissal

B. Fifth Circuit August 24, 1987 denial of petition for rehearing

C. District Court August 11, 1986 minute entry dismissing complaint

D. District Court November 12, 1986 minute entry denying motion for new trial

E. 29 U.S.C. §1001(a)

F. 29 U.S.C. §1133

TABLE OF AUTHORITIES

CASES	Page(s)
Amato v. Bernard, 618 F.2d 559 (9th Cir. 1980)	9,12,14
Denton v. First National Bank of Waco, Texas, 765 F.2d 1295 (5th Cir. 1985)	5,9,11-15
Heckler, Secretary of Health and Human Services v. Ringer, et al., 466 U.S. 602 (1984).....	13
Kross v. Western Electric Company, Inc., 701 F.2d 1238 (7th Cir. 1983)	14
Wolf v. National Shopmen Pension Fund, 728 F.2d 182 (3d Cir. 1984)	14

STATUTES	
28 U.S.C. §1254(1)	2
29 U.S.C. §1001 et seq.....	3
29 U.S.C. §1001(a)	2,8
29 U.S.C. §1133	i,2

PUBLICATION	
14 Pens. Rep. (BNA) No. 6 at 175 (February 9, 1987)	8

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Fifth Circuit has not been reported, pursuant to Local Rule 47.5, and is reproduced in the Appendix hereto at pp. A-1 through A-4 ("Opinion"). The order of the Fifth Circuit denying Petitioner's Petition for Rehearing has not been reported and is reproduced in the Appendix hereto at pp. A-5 through A-6.

The minute entry of the United States District Court for the Eastern District of Louisiana dismissing Respondents' complaint and that Court's minute entry denying Respondents' Motion for New Trial have not been reported and are reproduced in the Appendix hereto at pp. A-7 through A-9 and A-10 through A-13, respectively.

JURISDICTION

The order of the Court of Appeals for the Fifth Circuit was entered on July 22, 1987 (Appendix, pp. A-1 through A-4.)

A timely Petition for Rehearing was denied on August 24, 1987 (Appendix, pp. A-5 through A-6.) This Petition for Writ of Certiorari was filed within ninety days of that date.

This Court's jurisdiction is invoked pursuant to 28 U.S.C. §1254(1).

STATUTES INVOLVED

29 U.S.C. §1001(a) (reproduced in the Appendix at pp. A-14 through A-16)

29 U.S.C. §1133 (reproduced in the Appendix at p. A-17

STATEMENT OF THE CASE

This action arises from Respondents' claim for medical benefits under a self-insured group medical plan, the Hart Schaffner & Marx Subsidiary and Affiliated

Companies Group Life Insurance and Medical Plan ("the Plan"). The Plan is governed by the Employee Retirement Income Security Act, 29 U.S.C. §1001 et seq. ("ERISA").

Respondent Christopher Schultz was employed by Porter's-Stevens, then a wholly-owned subsidiary of Hart Schaffner & Marx ("HSM"), from December 28, 1981 to November 29, 1982. During his employment Mr. Schultz was a participant in the Plan.

The Schultz family suffered injuries as a result of a Pan American World Airways, Inc. ("Pan Am") jetliner crash on July 9, 1982. A few days after the accident, the Schultz family and their counsel were contacted by representatives of Pan Am and advised that Pan Am had arranged to pay all the costs associated with the medical care which the family required as a result of the accident. In total, the Schultz family received in excess of $7,321,000 from Pan Am

and/or its insurer for personal injuries and damages resulting from the crash.

On inquiry by Respondents' attorney about payment under the Plan for the medical services Respondents received as a result of the crash, HSM advised that Mr. Schultz should file a claim with the Plan for expenses not covered by Pan Am's program. Respondents' subsequent failure to provide necessary documentation compelled HSM (in November, 1984) to decline Respondents' purported claim; Respondents' attorney was specifically directed to Mr. Schultz's administrative appeal procedures available to challenge such disposition.[1]

---

1 The availability, nature and extent of such appeal procedures were known by Mr. Schultz as early as December 1981, when he actually received and reviewed the Summary Plan Description describing them. The Plan documents further specify in detail all of the administrative review processes. (See District Court minute entry at Appendix, p. A-9.)

Respondents refused to proceed with such remedies. Instead, they filed suit in the 24th Judicial District Court for the Parish of Jefferson, State of Louisiana, against Metropolitan Life Insurance Company ("Metropolitan"), as administrator of the Plan, and HSM, seeking benefits payments under the Plan. Metropolitan removed the case to the United States District Court for the Eastern District of Louisiana on the grounds of diversity of citizenship. Respondents thereafter amended their complaint to assert claims under ERISA against the Plan. (Metropolitan subsequently was dismissed and is not a party hereto.)

HSM and the Plan moved for summary judgment on April 2, 1986 upon a number of grounds, one of which was Respondents' failure to exhaust internal administrative remedies. The District Court, relying on the law of the Fifth Circuit in Denton v. First

National Bank of Waco, Texas, 765 F.2d 1295 (5th Cir. 1985), dismissed the complaint, without prejudice, for Respondents' failure to exhaust the administrative appeal procedures prior to filing suit. (Appendix, pp. A-7 through A-9.) Respondents challenged the dismissal by motion styled as one for a new trial. The District Court again reviewed Respondents' arguments respecting the application of the exhaustion doctrine, and specifically determined that its earlier ruling -- dismissing for failure to exhaust administrative remedies -- was correct (Appendix, pp. A-10 through A-13).

Respondents appealed from both the District Court's dismissal of their complaint and the denial of their Motion for New Trial. In December 1986, during the pendency of the appeal, Respondents finally requested an administrative review of the denial of benefits. That review was concluded in May,

1987. In June 1987, Respondents filed a second lawsuit in the District Court raising the same claims as the first.

The Court of Appeals for the Fifth Circuit did not decide whether the District Court's dismissal for failure to exhaust was erroneous. Instead, the Court of Appeals found that, since Respondents obtained administrative review (after, not before, the subject litigation), the issue of exhaustion appeared to be moot. Nevertheless, the Court of Appeals vacated the lower court's dismissal and remanded the case for consolidation with the second lawsuit.

REASONS FOR GRANTING THE WRIT

A. The Impact of ERISA

The existence and application of ERISA without doubt has fundamentally altered the landscape of employment law. The Act has dramatically improved employees' substantive rights in a variety of tangible and other

respects. Indeed, few employment laws have so profoundly affected as many Americans: tens of millions in the workplace enjoy the safeguards and security of ERISA-governed benefits plans, and clearly many more of their non-working dependents are within the protective ambit of such plans. See, 14 Pens. Rep. (BNA) No. 6 at 175 (February 9, 1987). That employee benefits plans under ERISA are affected with a vital, national public interest; represent an important factor in inter-state commerce and the very stability and development of industrial relations, and are desirable "for the protection of the revenue of the United States, and to provide for the free flow of commerce" are so established as to constitute specific Congressional findings and declarations of policy. 29 U.S.C. §1001(a).

B. ERISA's Exhaustion Requirement, and its Defeat by the Fifth Circuit.

The exhaustion doctrine has been judicially incorporated into ERISA. Amato v. Bernard, 618 F.2d 559 (9th Cir. 1980). Claimants under ERISA plans thus are required to exhaust administrative remedies provided thereunder before filing suit on any denial of benefits claim. The Fifth Circuit has earlier squarely adopted that mandate: "To preserve the integrity of ERISA, we hold as a matter of law that the doctrine of exhaustion of remedies is applicable to the denial of benefits by Plan trustees." Denton v. First National Bank, 765 F.2d 1295, 1297 (5th Cir. 1985).

The Fifth Circuit's Opinion in this case ignores the requirement under ERISA that a claimant exhaust his remedies before instituting a federal action. The District Court twice correctly determined that the exhaustion

doctrine was incorporated into the requirements of ERISA and is applicable to this case. The Opinion neither states nor implies that the District Court was erroneous, but indicated merely that the exhaustion issue appeared to be moot. Even so, the Court of Appeals vacated the dismissal, thus permitting Respondents to proceed on their original suit.

The requirement that Respondents adhere to the imperative of prior exhaustion has thus been disregarded. This remains true even though Respondents first failed, and then refused, to exhaust the requisite administrative remedies before, and even during, the District Court proceedings. Only after extensively litigating the point during 1985 and 1986, after receiving two adverse rulings by the District Court, and even after appealing the District Court's rulings, did

Respondents finally initiate the administrative process.

The Fifth Circuit vitiates, even abrogates, the clear and unequivocal determination recently enunciated by the Fifth Circuit, confirming that "we agree . . . that Congress, in enacting ERISA, clearly wanted potential plaintiffs to first exhaust their administrative remedies before resorting to the federal courts." Denton, 765 F.2d at 1303. (emphasis supplied). Respondents declined to proceed with such remedies, despite their actual knowledge thereof since 1981. The effect of the Opinion is: although the exhaustion doctrine applies and although claimants must meet its requirements before initiating their federal cause, if they fail to do so and the matter is raised as a defense, they still will be permitted to so exhaust - even if the federal cause already has been litigated! The rule

that a claimant must first exhaust thus becomes no rule at all, but merely a judicial preference.

Such effect is fundamentally opposed to the policies the Fifth Circuit has expressly adopted in Denton, and first articulated in Amato v. Bernard, 618 F.2d 559 (9th Cir. 1980). That the exhaustion doctrine applies hereto is manifest. So too are the considerations underlying the doctrine, controlling here: (a) to uphold Congress' desire that ERISA trustees be responsible for their actions - not the federal courts; (b) to provide a sufficiently clear record of administrative action if litigation ensues; (c) to assure that judicial review of fiduciary action (or inaction) is made under the arbitrary and capricious standard, and not de novo; (d) to prevent every ERISA action from literally turning into a federal case. Denton, 765 F.2d at 1300.

Respondents cannot gainsay the mandate that claimants must conclude the administrative process prior to instituting suit. Denton, 765 F.2d at 1303. If Respondents may freely ignore the prerequisite, secure in the knowledge that they will be permitted to exhaust during, or even after, the federal litigation, the prerequisite simply vanishes. Of what merit becomes the exhaustion doctrine when it is rendered purely optional?

This Honorable Court has not hesitated in analogous cases to grant certiorari "to sort out the thorny jurisdictional problems" presented where a claimant failed to proceed through designated levels of administrative review. Heckler, Secretary of Health and Human Services v. Ringer, et al., 466 U.S. 602 (1984). This Honorable Court therein upheld the correctness of the District Court's dismissal for failure to exhaust, forbidding the premature judicial intervention allowed by the Court of Appeals. Id.

Respondents' disregard of clear, available and known Plan remedies directly contravenes the Congressional intent recognized and applied twice by the District Court. Indeed, the consequence of the Opinion, which permits Plaintiffs to litigate an ERISA action without first exhausting administrative procedures, is the undesirable alteration, or eradication, of the Denton rule earlier adopted by the Fifth Circuit.

The elimination of the exhaustion requirement as judicially incorporated into ERISA stands in dramatic contrast to, and impermissible conflict with, all of the other Circuits which have ruled upon the point.[2] To permit exhaustion after litigation

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2 Wolf v. National Shopmen Pension Fund, 728 F.2d 182 (3d Cir. 1984) (ERISA requires claim exhaustion); Kross v. Western Electric Company, Inc., 701 F.2d 1238 (7th Cir. 1983) (well-established federal policy favors exhaustion of administrative remedies prior to bringing ERISA lawsuit in federal court) (emphasis added); Amato v. Bernard, 618 F.2d 559 (9th Cir. 1980) (Congress intended to grant authority to the courts to

shatters at once the rule and the rationale of its underlying policy considerations.

CONCLUSION

For the reasons stated above, we urge that this Petition for Writ of Certiorari be granted.

Respectfully Submitted,

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CONT'D

apply the exhaustion requirement in suits under ERISA). Denton, of course, discussed in the body, has been the law of the Fifth Circuit.

APPENDICES

TABLE OF CONTENTS

	Page
Fifth Circuit July 22, 1987 order vacating dismissal	A-1
Fifth Circuit August 24, 1987 denial of petition for rehearing	A-5
District Court August 11, 1986 minute entry dismissing complaint	A-7
District Court November 12, 1986 minute entry denying motion for new trial	A-10
29 U.S.C. §1001(a)	A-14
29 U.S.C. §1133	A-17

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 86-3870

BARBARA AND CHRISTOPHER
SCHULTZ, Etc.,
Plaintiffs-Appellants,

v.

METROPOLITAN LIFE INSURANCE
COMPANY,
Defendant,

and

HART SCHAFFNER & MARX
(HARTMARX CORPORATION),
Defendant-Appellee.

Appeal from the United States
District Court for the Eastern
District of Louisiana

Before: Rubin, Garza and Jolly
Circuit Judges

PER CURIAM:*

The issue presented in this appeal is whether the district court abused its discretion by not excusing the plaintiffs' failure to exhaust their administrative remedies as required by the Employment

Retirement Income Security Act, 29 U.S.C. § 1001 et seq. ("ERISA"). Because this issue now appears to be moot, we vacate the dismissal of the complaint and remand this case to be consolidated with the plaintiffs' ERISA action now pending before the district court.

I

On July 9, 1982, a Pan American Air Lines jet aircraft crashed into the Schultzes' home. Pan American's insurance representative contacted the Schultzes and arranged to pay their medical costs resulting from the crash. More than one year after the accident, the Schultzes submitted claims for

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*Local Rule 47.5 provides: "The publication of opinions that have no precedential value and merely decide particular cases on the basis of well-settled principles of law imposes needless expense on the public and burdens on the legal profession." Pursuant to that Rule, the court has determined that this opinion should not be published.

medical expenses not paid by Pan American to Mr. Schultz' employer, Porter-Stevens, a wholly owned subsidiary of Hart, Schaffner & Marx ("HSM"). HSM denied the Schultzes' claim for over $170,000 in medical expenses. Rather than pursue their administrative appeal rights, the Schultzes filed suit in a Louisiana state court against HSM, HSM's health insurance plan ("the Plan"), and the insurer, Metropolitan Life Insurance Co.

Following removal of the case to federal court, the district court dismissed the Schultzes' complaint without prejudice for failure to exhaust their administrative remedies. The Schultzes appealed.

Pending their appeal, the Schultzes requested administrative review of their claim. Counsel informed this panel at oral argument that the Plan has recently denied the Schultzes' administrative appeal and that

the Schultzes have filed a new lawsuit in the district court raising the same claims that are presented in this case.

II

Because the Schultzes have now sought and been denied their administrative remedies, the issue of exhaustion raised in this appeal appears to be moot. In the light of these circumstances, we vacate the dismissal of the complaint and remand this case for consolidation with the Schultzes' lawsuit now pending before the district court so that all issues raised in this appeal may be presented in one case before the district court and, if necessary, heard in one appeal before this court.[1]

VACATED AND REMANDED.

---

[1]It is clear that this disposition of the case does not prejudice the Schultzes in raising before the district court the issues presented in this appeal.

Dated: July 22, 1987

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 86-3870

BARBARA AND CHRISTOPHER
SCHULTZ, Etc.,
Plaintiffs-Appellants,

v.

METROPOLITAN LIFE INSURANCE
COMPANY,
Defendant,

and

HART SCHAFFNER & MARX
(HARTMARX CORPORATION),
Defendant-Appellee.

Appeal from the United States
District Court for the Eastern
District of Louisiana

Before: Rubin, Garza and Jolly
Circuit Judges

PER CURIAM:

IT IS ORDERED that the appellees' petition for rehearing is denied. The panel opinion vacated and remanded this appeal for consolidation with the related lawsuit now

pending before the district court; our disposition of the case in no way prejudices the parties from raising before the district court the issues they presented before our panel. Indeed, the opinion clearly holds that all issues in the appeal are preserved for resolution in one case before the district court and, if necessary, in one appeal.

Dated: August 24, 1987

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

BARBARA AND CHRISTOPHER SCHULTZ, INDIVIDUALLY AND ON BEHALF OF THEIR MINOR DAUGHTER, RACHEL SCHULTZ, Plaintiffs	)	C.A. NO. 85-2368
vs.	)	
HART SCHAFFNER & MARX SUBSIDIARY AND AFFILIATED COMPANIES GROUP LIFE INSURANCE AND MEDICAL PLAN (THE PLAN), HART SCHAFFNER & MARX, Defendants.	)	MINUTE ENTRY

Before: Arceneaux, J.

Presently before the Court are numerous motions for summary judgment filed by defendants Hart, Schaffner & Marx and Hart, Schaffner & Marx Subsidiary and Affiliated Companies Group Life Insurance and Medical Plan, and plaintiffs' cross-motions for summary judgment. All motions were submitted without oral argument. Finding that plaintiffs' [sic] failed to exhaust their administrative remedies, IT IS ORDERED that their complaint is DISMISSED WITHOUT

PREJUDICE and all other motions are DISMISSED AS MOOT.

The exhaustion doctrine has been judicially incorporated into ERISA, Amato v. Bernard, 618 F.2d 559 (9th Cir. 1980). Plaintiffs justify their failure to exhaust by relying on the exception that administrative appeals would be futile, Amato; Denton v. First Nat. Bank of Waco, Texas, 765 F.2d 1295 (5th Cir. 1985). Excusing exhaustion on the grounds of futility is within the trial court's discretion, subject to review only for an abuse of that discretion, Denton. Plaintiffs' mere allegations of futility on the basis that the people to hear the appeal are hostile is clearly not sufficient to allow this Court to find the administrative appeal is futile, and it would be an abuse of discretion to do so.

Plaintiffs' claim that they should not have to exhaust their remedies because they were not notified of their appeal rights is without merit. Plaintiffs received and "looked through" the plan description containing the appeal process and are therefore aware of their appeal rights Noell v. American Design, Inc., Profit Sharing Plan, 764 F.2d 827 (11th Cir. 1985). Defendants discharge their duty to inform a plan participant by providing an accurate and thorough plan description. Genter v. Acme Scale & Supply Co., 776 F.2d 1180, 1184 (3rd Cir. 1985) citing Allen v. Atlantic Richfield Retirement Plan, 480 F. Supp. 848 (E.D. Pa. 1979).

(SIGNATURE)

Dated: August 11, 1986

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

BARBARA AND CHRISTOPHER SCHULTZ, INDIVIDUALLY AND ON BEHALF OF THEIR MINOR DAUGHTER, RACHEL SCHULTZ, Plaintiffs	)	C.A. NO. 85-2368
vs.	)	
HART SCHAFFNER & MARX SUBSIDIARY AND AFFILIATED COMPANIES GROUP LIFE INSURANCE AND MEDICAL PLAN (THE PLAN), HART SCHAFFNER & MARX, Defendants.	)	MINUTE ENTRY

Before: Arceneaux, J.

ORDER AND REASONS

Currently before the Court is the motion of the plaintiffs for a new trial. For the reasons assigned below, the motion is DENIED.

BACKGROUND

On July 9, 1982, a Pan American Airlines jetliner crashed into the home of Barbara and Christopher Schultz. The tragedy took the life of one of their children and seriously injured Mrs. Schultz and their other child. Mr. Schultz was not at home at the time

disaster struck but allegedly suffered emotional disturbances as a result of the accident.

Mr. Schultz was employed by Porter-Stevens, which was a subsidiary of Hart, Schaffner & Marx Co. (HSM). Mr. Schultz was enrolled in a family health insurance plan called the Hart, Schaffner & Marx Subsidiary and Affiliated Companies Group Life Insurance and Medical Plan, which was administered by Metropolitan Life Insurance Co.

Mr. and Mrs. Schultz gave notice to Porter-Stevens and HSM that they were claiming medical benefits under the plan. HSM denied the claim and Mr. and Mrs. Schultz filed the present lawsuit.

By minute entry dated August 11, 1986, this Court dismissed the plaintiffs' claims without prejudice. The basis for the ruling was that the plaintiffs had not exhausted their extrajudicial remedies because they

failed to administratively appeal the denial of their claim.

Now the plaintiffs, by way of a motion for a new trial, ask the Court to reconsider its prior holding. The plaintiffs renew their argument that an administrative appeal would have been futile and that they should be excused from the requirement of exhaustion. To support this contention, the plaintiffs have presented evidence that their claim was not treated in the same manner as claims made by other employees and that some members of the appeal board had already denied their claim when it was first presented. In addition, they note that no employee had ever appealed a denial of benefits before.

After considering the plaintiff's [sic] arguments, this Court remains convinced that its initial decision to dismiss for failure to exhaust administrative remedies was

correct. First, even if the defendants did depart from normal procedures in handling this case, that is not reason to conclude that an appeal would be futile. Indeed, a major purpose of appeal is to correct deviations from established standards. The fact that other employees' claims were handled differently from that of the plaintiff also helps explain why no appeals had ever been taken.

Finally, the contention that members of the appeals board had already denied the plaintiffs' claims does not render the availability of an appeal futile. This Court and the plaintiffs simply cannot assume that those members of appeals board would refuse to consider whatever the plaintiffs had to say on appeal.

Accordingly, IT IS ORDERED that the motion of the plaintiffs for a new trial is DENIED.

Dated: November 12, 1986

29 U.S.C. §1001:

(a) The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the

activities of such plans is carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect

to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

29 U.S.C. §1133:

In accordance with regulations of the Secretary, every employee benefit plan shall -

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

Supreme Court, U.S.
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NO. 87-850

In the Supreme Court of the United States

October Term, 1987

HART SCHAFFNER & MARX and HART SCHAFFNER & MARX SUBSIDIARY AND AFFILIATED COMPANIES GROUP LIFE INSURANCE AND MEDICAL PLAN,
Petitioners

v.

BARBARA AND CHRISTOPHER SCHULTZ individually and on behalf of their minor daughter, RACHAEL SCHULTZ,
Respondents.

On Writ of Certiorari To
The United States Court of
Appeals for the Fifth Circuit

OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

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TABLE OF CONTENTS

	Page
TABLE OF CONTENTS	i
TABLE OF AUTHORITIES	ii
STATEMENT OF THE CASE	1
SUMMARY OF ARGUMENT	7
ARGUMENT	8
CONCLUSION	15

APPENDICES:

A. Motion of Defendants-Appellees to Dismiss Appeal on Grounds of Mootness;

B. United States Court of Appeals Fifth Circuit, Questions to be addressed.

TABLE OF AUTHORITIES

CASES Page(s)

Challenger v. Local Union No. 1, 619 F. 2d 645 (7th Cir. 1980) 12

Ellenburg v. Brockway, Inc., 763 F. 2d 1091, 1096 (9th Cir. 1985) 11

Grossmuller v. International Union, UAW, 511 F. Supp. 709, (E.D. Pa. 1981) 12

Pond v. Braniff Airways, Inc., 453 F. 2d 347 (5th Cir. 1972) 10

Stein v. Reynolds, 667 F. 2d 33 (11th Cir. 1982) 10

Wolf v. J.C. Penney Co., Inc., 710 F. 2d 388 (7th Cir. 1983)..... 11

STATUTES

29 U.S.C. Sec. 1132 (a)(3)(b)... 13

Rules of the Supreme Court of the United States, Rule 17 ..... 15, 17

Rules of the United States Court of Appeals for the Fifth Circuit, Rule 47.5 14

STATEMENT OF THE CASE

This matter arises out of $170,000 of medical expenses incurred by Respondents, the Schultz family, as a result of injuries they sustained in a Pan American World Airways jetliner crash on July 9, 1982. At the time of the crash the Schultz family were participants or beneficiaries under the Hart Schaffner and Marx Subsidiary and Affiliated Companies Group Life Insurance and Medical Plan ("the Plan"). This plan was administered by Hart Schaffner and Marx ("HSM"), the parent company of Porter Stevens, the employer of Christopher Schultz. Both the Plan and HSM are Petitioners herein.

The request for payment of these expenses was diverted from the normal claims handling procedure (which included routing to the administrative services provider, Metropolitan Life Insurance) and handled by the Legal Department of the

administrator, HSM. After receiving all information regarding the medical expenses, including the fact that Pan Am would pay for these same medical expenses in its position as a third party tortfeasor, under its liability obligations, the Plan denied the claim. The Plan, acting through its general counsel, Carey Stein, twice deceived Respondents into thinking that their claim was being processed by the administrative services provider when it was not. The ground for the denial, that a third party tortfeasor would pay these same medical expenses, is not based on the terms of the Plan. There is no subrogation clause, nor is there any exclusion for amounts which may be collected from a third party tortfeasor. The Plan simply felt it was not fair to allow coverage for these amounts.

After Respondents filed suit to recover these expenses HSM and the Plan sought dismissal on the grounds that Respondents failed to exhaust their administrative remedies under the Employee Retirement Income Security Act ("ERISA"). The District Court rejected Respondents' position that an appeal would have been futile and dismissed the case, without prejudice, on the grounds that Respondents had failed to exhaust administrative remedies by appealing the Plan's denial. Respondents had claimed that an appeal would have been futile because 1) an appeal would have been to the same exact persons who had (a) diverted the claim from the normal claim procedure, and (b) deceived the claimants that their claim had been turned over to the administrative services provider, when it had not and 2) there was simply no basis under the language of the Plan for the denial, and

thus to ask the chief counsel for HSM to review his own "groundless" interpretation of the Plan used to deny the claim would have been futile.

Respondents asserted two basic arguments on appeal; 1) that any further review would have been futile; and 2) the dismissal without prejudice could effectively bar any future judicial review because prescription would have run. (Respondents cited the appellate court to jurisprudence supporting the fact that the filing of a lawsuit which is subsequently dismissed without prejudice does not interrupt the prescriptive period. Because the prescriptive period in this matter would have run by the time another lawsuit could be filed it would have effectively barred any court from judicially reviewing this matter once the administrative appeal had been completed.)

While this appeal was pending Respondents sought an administrative review through the Plan, which was concluded in May, 1987, wherein the Plan, as expected, again denied the claim. Prior to the Plan denying this claim, but after the administrative review was sought, Petitioners asked the Appellate Court to dismiss the appeal on the grounds that it had become moot because Respondents had sought the administrative appeal. (Appendix A.)

Prior to oral argument the Court of Appeals for the Fifth Circuit provided counsel with four questions which were to be addressed either orally or in writing in advance of oral argument. (Appendix B) A review of these questions indicates that the panel was very concerned over the second major issue raised by Respondents in their appeal; that is whether the dismissal by the District Court, without

prejudice, would act as a bar to any judicial review of the Schultz claim once administrative prerequisites had been met.

This became evident during oral argument when the only issue addressed by the panel was whether it would be appropriate to completely bar judicial review on the grounds that the procedural prerequisites to filing a lawsuit had not been followed. During oral argument counsel for Petitioners candidly admitted that he knew of nothing in the Plan which would prohibit the Plan from delaying administrative review until after the prescriptive period for filing a lawsuit had expired.

Based on this background the Court of Appeal vacated the dismissal without prejudice and remanded this matter back to the District Court so that judicial review of the claim denial could be heard.

(Appendix A of Petition for Writ of Certiorari)

SUMMARY OF ARGUMENT

The Court should not grant this Writ of Certiorari because Petitioners have cited no classification under Rule 17 of this Court's rules in which this matter falls. Although the appellate briefs addressed many ERISA issues, the decision rendered by the Court of Appeals for the Fifth Circuit is purely a procedural decision which did not address any of the ERISA issues. Instead, the decision and denial of rehearing specifically stated that all issues raised on appeal were preserved for argument upon remand to the District Court. Neither of the two decisions rendered by the District Court, nor the decision of the Court of Appeals were deemed significant enough to even publish in the reporter system. Cases which are not even significant enough to

publish in the reporter systems certainly cannot be significant enough to be reviewed by this Honorable Court.

ARGUMENT

It is respectfully suggested that this Honorable Court should deny the Petition for Writ of Certiorari because:

a) The Court of Appeals decision is purely a procedural one which does not address ERISA issues at all; and

b) The decisions of the District Court and Court of Appeals were not even deemed to be significant enough to publish.

Instead, this petition is a "last ditch" effort on the part of Petitioners to obtain a substantive remedy (complete denial of the claim) from a procedural defect, something which the Court of Appeals refused to do. Petitioners hope by obtaining this Writ of Certiorari that they can prevent Respondents from ever having

a court of law review this claim denial, thus denying them their day in court and procedural due process.

a) Only a procedural case

Petitioners have asserted that the decision of the Fifth Circuit Court of Appeals will have an impact on ERISA. As one can see from the decision, it was purely a procedural decision to vacate the dismissal without prejudice so that Respondents would have an opportunity to present all issues before the District Court. The decision did not address the ERISA issues before the Appellate Court. In fact, in the denial of the Petition for Rehearing the Appellate Court stated:

> Indeed, the opinion clearly holds that all issues in the appeal are preserved for resolution in one case before the District Court and, if necessary, in one appeal.

(Appendix B at A-6 of Petition for Writ of Certiorari.)

The justification for vacating the District Court's dismissal was the possibility that the dismissal without prejudice may have barred Respondents from ever seeking a judicial review of the claim denial. There was some case authority that the filing of a complaint in a case which is subsequently involuntarily dismissed would not toll the prescriptive period. Pond v. Braniff Airways, Inc., 453 F. 2d 347 (5th Cir. 1972); Stein v. Reynolds, 667 F. 2d 33 (11th Cir. 1982). Since the prescriptive period for filing a lawsuit by Respondents against Petitioners would already have run when it was dismissed, Respondents would have been forever prevented

from seeking a judicial review of the Plan's denial.

It is settled that procedural defects do not necessarily require substantive remedies. A substantive remedy would be appropriate only if the procedural defects caused a substantive violation or themselves worked a substantive harm. Ellenburg v. Brockway, Inc., 763 F. 2d 1091, 1096 (9th Cir. 1985); Wolfe v. J.C. Penney Co., Inc., 710 F. 2d 388 (7th Cir. 1983). By dismissing Respondents' action without prejudice, thus preventing a judicial review of the Plan's actions, the Plan would have obtained a substantive remedy (no responsibility for $170,000 of medical expenses) as a result of a procedural defect (failure to appeal the claim denial).

As the court in Grossmuller v.International Union, UAW, 511 F. Supp. 709, 710 (E.D. Pa. 1981) noted: "cases are sparse on this issue, but as a matter of common sense, a [party] is not entitled to a substantive remedy merely because of a procedural violation."

What a court should do, as the Court of Appeals did in this case, is to fashion some remedy to correct the procedural deficit if necessary. In the Grossmuller case cited above, to correct a failure to give notice the court ordered appropriate notice be given and a hearing be set. 511 F. Supp. at 710. Likewise, in Challenger v. Local Union No. 1, 619 F. 2d 645 (7th Cir. 1980) due to the failure of the Plan to mention arbitration and advise of steps necessary to proceed along those

lines, the court extended the employee's time for requesting arbitration. The Court of Appeals agreed in the case at bar that a substantive remedy was not warranted and thus vacated the dismissal. This action is allowed under ERISA, 29 USC Sec. 1132 (a)(3)(B) allowing the award of "other appropriate equitable relief".

This Petition for Certiorari is Petitioners' final effort to escape responsibility for this claim because of an alleged procedural defect, which the Appellate Court did not even affirm as to being a procedural defect. The Appellate Court held that the Schultz family should be allowed to have a court review the Plan's decision. Petitioners hope that this Honorable Court will take that right away from Respondents.

This must not be done.

b. Lack of precedential value of the District and Appellate Court Decisions

Neither the minute entry of the United States District Court for the Eastern District of Louisiana dismissing Respondents' complaint, nor that court's minute entry denying Respondents' Motion for New Trial were reported. Furthermore, the opinion of the United States Court of Appeals for the Fifth Circuit was not reported in accordance with Local Rule 47.5. According to that Local Rule, the Fifth Circuit essentially felt that this decision had no precedential value and was merely decided on the basis of well settled principals of law and that publication of the decision would impose needless expense on the public and burden the legal profession. (See

page A-2 of Petition for a Writ of Certiorari)

Since none of the lower courts even deemed their decisions worthy of publication, then Respondents respectfully suggest that this Honorable Court should not feel that it should be worthy of further review in light of the many other categories of cases falling squarely within Rule 17 which do in fact have precedential value. Therefore for this reason also, the Writ of Certoriari should be denied.

CONCLUSION

Contrary to the argument raised by Petitioners, this case does not involve ERISA. The Appellate Court did not address any of the ERISA issues raised there. Instead, the Appellate Court felt that the ERISA issues had been "mooted" by the

subsequent review of the claim by the Plan. (something Petitioners themselves argued in their Motion to Dismiss the Appeal.) However, the Appellate Court correctly recognized that there was a danger that Petitioners would obtain a substantive remedy "absolution from liability for the $170,000 claim" because of a procedural defect "lack of an administrative review" as a result of the District Court's dismissal without prejudice. To avoid this danger, and to assure Respondents' right to a judicial review of the Plan's claim denial, the Fifth Circuit vacated the District Court's dismissal without prejudice and remanded the matter to the District Court. Any review by this Court would simply be reviewing a procedural decision, something

which falls nowhere within Rule 17. Furthermore, it is hard to conceive that a decision which none of the lower courts deemed significant enough to publish and one which the Fifth Circuit felt had no precedential value can be of such a magnitute as to fall within Rule 17 of this Honorable Court's rules. Thus, Respondents respectfully suggest that this Petition for Writ of Certoriari should be denied.

Respectfully submitted,

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APPENDICES

TABLE OF CONTENTS

	Page
Motion of Defendants - Appellees to Dismiss Appeal of Grounds of Mootness	A-1
United States Court of Appeals Fifth Circuit, Questions to be addressed	A-11

APPENDIX A

IN THE UNITED STATES COURT OF APPEALS

FOR THE FIFTH CIRCUIT

NO. 86-3870

BARBARA AND CHRISTOPHER SCHULTZ, individually and on behalf of their minor daughter, RACHAEL SCHULTZ
Plaintiffs-Appellants.

v.

METROPOLITAN LIFE INSURANCE COMPANY, HART SCHAFFNER & MARX and HART SCHAFFNER & MARX SUBSIDIARY AND AFFILIATED COMPANIES GROUP LIFE INSURANCE and MEDICAL PLAN
Defendants-Appellees.

Appeal from the United States District Court for the Eastern District of Louisiana

MOTION OF DEFENDANTS-APPELLEES TO DISMISS APPEAL ON THE GROUNDS OF MOOTNESS

Now come Hart Schaffner & Marx ("HSM") and Hart Schaffner & Marx Subsidiary and Affiliated Companies

Group Life Insurance and Medical Plan ("the Plan"), by their undersigned counsel, and, moving this Honorable Court to dismiss the instant Appeal of the Plaintiffs-Appellants ("Plaintiffs") on the ground of mootness, and in support thereof, move and state as follows:

1. Occurrences after the entry of the District Court's orders appealed from has rendered Plaintiff's Appeal moot. On August 12, 1986, the District Court dismissed Plaintiffs' Complaint (without prejudice) by reason of Plaintiffs' failure to exhaust administrative remedies as required in connection with a self-insured benefits plan governed by the Employee Retirement Income Security Act, 29 U.S.C. Sec. 1001 et. seq. ("ERISA") (R. 1233-34).

2. Plaintiffs sought to overturn such dismissal by post-judgment motion which acknowledged their failure to seek the requisite administrative review, but asserted they were justifiably unable to obtain such review and that they should be excused from the exhaustion requirement; it was claimed that adminitrative review would have been "futile" (R. 1251).

3. On November 12, 1986, the District Court denied such motion of Plaintiffs, again holding that exhaustion of administrative remedies was required. The Court once again considered, and rejected, Plaintiffs' allegations of futility (R. 1289-90).

4. Plaintiffs filed their Notice of Appeal on December 8, 1986, (R. 1294) and their Original Brief on February 12, 1987. Plaintiffs urge

this Honorable Court to reverse the District Court's two decisions, since the requirement that Plaintiffs exhaust their administrative remedies should be excused, it is asserted, because (a) Plaintiffs did not or could not obtain such review because of their lack of notice of such rights; and (b) such review is, and was at all material times, futile.

5. Following the entry of said District Court order, Plaintiffs requested - and were granted - administrative review of the subject claim by the Hartmarx Group Medical Plan Claims Appeal Committee ("Benefits Appeal Committee"). Such review is ongoing and is currently proceeding at Plaintiffs' special instance and request. More specifically:

(a) On December 4, 1986, after the entry of the District Court orders but before appeal therefrom was taken, Plaintiffs' counsel requested "an appeal of the Plan's denial of their claim for medical benefits under the Plan . . . This appeal is being taken in accordance with the rules of your Plan and ERISA" (December 4, 1986 letter of Edward F. Downing, III, attached hereto as Exhibit A).

(b) On January 16, 1987 (after other, preliminary correspondence was forwarded to Plaintiffs' counsel), the Benefits Appeal Committee granted such request, advising Plaintiffs' counsel as to the purpose, procedures and time schedules respecting such administrative review (January 16, 1987 letter of Sherman D. Rosen, Benefits Appeal Committee

Chairperson, attached hereto as Exhibit B).

(c) Plaintiffs' counsel has thereafter forwarded to the Benefits Appeal Committee all of the materials, written statements and arguments applicable to such administrative review; said Committee has met on a number of occasions to review the merits of Plaintiffs' administrative appeal; Plaintiffs have submitted other and further documentation in support thereof, which have been and will be considered by said Committee; and most recently, Plaintiffs have accepted the Committee's invitation for an oral telephonic hearing in connection therewith, and all pursuant to the correspondence of Plaintiffs' counsel and of said Committee and the Affidavit attached

hereto as Group Exhibit C and Exhibit D, respectively.

6. Plaintiffs' request for administrative review following the entry of the District Court Orders, and the granting of such review, thus has provided Plaintiffs with the very relief they claimed they could not obtain, and from which they sought to be excused. The issues raised by the instant appeal are no longer alive. Plaintiffs prosecute the instant appeal - squarely based upon the supposed unavailability and futility of administrative review - even as they enjoy the rights and privileges of the same administrative review process. Plaintiffs' post-judgment initiation of their administrative appeal process accordingly has rendered the instant judicial appeal moot.

7. Moreover, Plaintiffs' principal argument for the supposed futility of any administrative review process is the claim that the reviewers would have been the same persons who denied the claim in the first instance. Such theory is not warranted under existing law and has been repeatedly disapproved. See, for example Denton v. First National Bank of Waco, Tex. 765 F.2d 1295 (5th Cir. 1985). Even so, the very premise of the argument is simply false. After Plaintiffs requested administrative review on December 4, 1986 (but before they filed the instant judicial Appeal), the Benefits Appeal Committee designated to so investigate, examine and review were and are five persons, none of whom are alleged by Plaintiffs to have denied any part of the

underlying claim (See, Affidavit of Sherman D. Rosen, Benefits Appeal Committee Chairperson, attached hereto as Exhibit D).

By reason of events initiated by Plaintiffs and occurring after the entry of the lower court orders, the issues raised by Plaintiffs' Appeal accordingly are moot.

In further support hereof, Defendants-Appellees respectfully submit their Memorandum of Law attached hereto.

WHEREFORE, Defendants-Appellees respectfully move this Honorable Court to strike and dismiss Plaintiffs Appeal with costs and fees taxed to Plaintiffs.

Respectfully submitted,

_____

One of the Attorneys for
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APPENDIX B

UNITED STATES COURT OF APPEALS

Fifth Circuit

TO: Counsel

SUBJECT: No. 86-3870 - Barbara and Christopher Schultz, etc. v. Metropolitan Life Ins. Co. and Hart Schaffner & Marx

After reviewing the briefs in this matter, the court had a few questions that at least one of the judges who will hear your argument knows in advance he would like to have answered or commented on in oral argument. Knowing that interruption of counsel to put these questions may interfere with counsel's train of thought, and desiring also to give counsel at least some opportunity to reflect on the questions, we are submitting them to you. We suggest that you try to answer them as directly as possible.

You are to answer these questions either orally at oral argument or by delivering an answer in writing (a handwritten copy will suffice) to the Clerk before oral argument and giving a copy to opposing counsel. You are not to file a post argument memo or brief unless specifically authorized to do so by the oral argument panel.

Of course, the fact that the court desires to know your answers to these questions must not be taken as an indication of the direction of the

court's thoughts or of the issues that the court considers decisive. Instead, they are part of the court's effort to understand the case as completely as possible.

You will likely be asked to answer other questions from members of the court as your argument proceeds. These, too, are designed merely to enable the court to understand your position. We hope that you will welcome the opportunity to give us as much information as possible.

The questions that we know at this time are the following:

Questions for both counsel:

1. What is the status of the administrative appeal?

2. Has prescription been tolled by the plaintiff's efforts to obtain administrative remedies? If so, how much of the prescriptive time period could have elasped?

3. Under Louisiana law, prescription is interrupted by the filing of suit or service of process, La. Civil Code Art. 3462, unless the plaintiff abandons, voluntarily dismisses, or fails to prosecute the suit, La. Civil Code Art. 3463. Do these provisions apply here?

4. If this court decides that administrative remedies must be exhausted, should we vacate the dismissal and grant a stay pending exhaustion?

No. 87-850

Supreme Court, U.S.
FILED
JAN 11 1988
JOSEPH F. SPANIOL, JR.
CLERK

In The Supreme Court of the United States

October Term, 1987

HART SCHAFFNER & MARX and HART SCHAFFNER & MARX SUBSIDIARY AND AFFILIATED COMPANIES GROUP LIFE INSURANCE AND MEDICAL PLAN,
Petitioners,

v.

BARBARA AND CHRISTOPHER SCHULTZ, individually and on behalf of their minor daughter, RACHAEL SCHULTZ,
Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

PETITIONERS' REPLY TO OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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TABLE OF CONTENTS

	Page
INTRODUCTION	1
ARGUMENT	1
APPENDIX	A-1

TABLE OF AUTHORITIES

	Page(s)
Amato v. Bernard, 618 F.2d 559 (9th Cir. 1980)	6
Denton v. First National Bank of Waco, Texas, 765 F.2d 1295 (5th Cir. 1985)	5, 6

I

INTRODUCTION

The Question Presented; Parties to the Proceedings; Opinions Below; and Statements of Jurisdiction, of the Case and of subsidiary and affiliate relationships are fully set forth in Petitioners' Petition for a Writ of Certiorari.

II

ARGUMENT

Respondents' Opposition Brief addresses a number of the facts and issues which the parties disputed in the trial court, but offers little to establish that this Honorable Court should refuse to hear this matter. The District Court twice determined that Respondents' action was required to be dismissed for failure to exhaust administrative remedies, and the Opposition Brief seems intent to again raise, and impermissibly

reargue in these papers, contested facts or matters simply not germane.

The opposition to the granting of the Writ appears to be primarily grounded upon assertions that this cause presents only procedural or "insignificant" matters, not worthy of the attention of this Court. In doing so, the Opposition not only misrepresents the Plan's requirements respecting administrative review, but also overlooks the nature and import of the exhaustion doctrine itself.

For example, Respondents allude to a supposed ability of the Plan to somehow delay administrative review until after a prescriptive period ran. This assertion is utterly false. Section 7.4 of the Plan document specifies that:

> Within 10 days of receiving a request for review, the Named Fiduciary shall acknowledge in writing to the person

filing the request the receipt thereof and the date of such receipt. The Named Fiduciary shall then review the matter and, after such consultation with the Participant or Beneficiary and Insurer as the Named Fiduciary deems appropriate, shall render a decision to the Participant or Beneficiary, which decision shall be made not later than 60 days following receipt of the request for review, unless special circumstances require an extension of time for processing, in which case a decision shall be rendered as soon as possible, but not later than 120 days following receipt of the request for review. Except as may be otherwise required by law, the decision of the Named Fiduciary shall be binding on all parties. (emphasis added)

The Plan document is set forth in its entirety in the Appendix hereto.

Understandably, Respondents do not refer in Opposition to their actual acknowledge of the availability, nature and extent of administrative appeals procedures as early as December 1981, nor to their receipt of written direction thereto in 1984, nor to their determined refusal throughout 1985 and 1986 to seek such administrative review, preferring instead to litigate in the District Court in efforts to excuse such review.

It is precisely these kinds of litigation proceedings which are forbidden by the Fifth Circuit by its determination that claimants under ERISA plans are required to exhaust administrative remedies provided thereunder before filing suit on any denial of benefits claims: "To preserve the integrity of ERISA, we hold as a matter of law that the doctrine of exhaustion of

remedies is applicable to the denial of benefits by Plan Trustees." Denton v. First National Bank, 765 F.2d 1295, 1297 (5th Cir. 1985). It is stipulated that Respondents are claimants under an ERISA plan, and it is undisputed that administrative review was not sought until after the District Court litigation and, indeed, until after Respondents appealed the dismissal of their action in December 1986.

The Fifth Circuit's opinion, which allows the original cause to proceed, simply abrogates the exhaustion doctrine and the Fifth Circuit's own unequivocal determination that "we agree . . . that Congress, in enacting ERISA, clearly wanted potential plaintiffs to first exhaust their administrative remedies before resorting to the federal courts. Denton, 765 F.2d at 1303. If claimants may permissibly exhaust either before or after they litigate their federal

cause, the requirement of prior exhaustion is obviously disregarded. This is deemed "insignificant" in the Opposition.

The doctrine exists, at least in part, to prevent every ERISA action from literally turning into a federal case. Amato v. Bernard, 618 F.2d 559 (9th Cir. 1980); Denton, 765 F.2d at 1300. Respondents have not, and cannot, offer any adequate justification for the suspension, if not abrogation, of the exhaustion doctrine, so recently adopted by the Fifth Circuit. To permit Respondents to exhaust after, not before, they prosecute their federal case upends both the rule and its sound policy reasons.

CONCLUSION

For the reasons stated above, we urge that the Petition for Writ of Certiorari be granted.

Respectfully submitted,

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APPENDIX

HART SCHAFFNER & MARX
SUBSIDIARY AND AFFILIATED COMPANIES
GROUP INSURANCE AND MEDICAL BENEFITS PLAN

SECTION I

INTRODUCTION

This Group Insurance and Medical Benefits Plan has been established by Hart Schaffner & Marx in order to provide life and liability insurance and medical benefits for eligible employees.

The effective date of the Plan was October 15, 1956. The Plan, as amended through March 1, 1976, is set forth below.

SECTION 2

DEFINITIONS

2.1 Definitions

The following words and phrases shall have the meanings stated below unless a different meaning is plainly required by the context:

1. "Plan" means the plan described in this instrument and known as "Hart

Schaffner & Marx, Subsidiary and Affiliated Companies Group Insurance and Medical Benefits Plan," as the same may, from time to time, be amended. "Company" means Hart Schaffner & Marx, a New York corporation.

2. "Subsidiary" means any United States corporation of which Hart Schaffner & Marx is the owner of more than 50% of the shares of its outstanding stock having voting rights.

3. "Affiliate" means any corporation of which a Subsidiary is the owner of more than 50% of the shares of its outstanding stock having voting rights.

4. "Employer" means the Company, in case the participant is employed by the Company; it means the

Subsidiary or Affiliate participating in the Plan by which the participant is employed, in all other cases.

5. "Board of Directors" means the Board of Directors of Hart Schaffner & Marx

6. "Employee" means any individual who is in the regular full-time service and employ of the Employer, working at least 1,000 hours per year, but the term "employee" shall not include a member of the Board of Directors of the Employer unless such member is also an officer or employee of the Employer, and shall not include a temporary, seasonal or part-time employee.

7. "Annual Earnings" means the aggregate amount of compensation, including overtime, paid to an

employee by the Employer during a calendar year.

8. "Participant" means an employee who has become a participant under the provisions of Section 4.

9. Use of the masculine pronoun shall be deemed to include the feminine unless the context clearly indicates the distinction.

SECTION 3

DESIGNATION OF FIDUCIARY: ADMINISTRATION

The Company is designated as the Named Fiduciary of the Plan in accordance with the pertinent provisions of the Employee Retirement Income Security Act of 1974. The Company shall be the Plan Administrator responsible for the general administration of the Plan and carrying out the provisions thereof. The Company shall have all such powers as may be necessary to carry out the provisions of the Plan and from time to time

establish rules and regulations for the administration of the Plan and the transaction of the Plan's business. An officer of the Company designated by the Chairman or President of the Company shall cause benefits to be paid to persons entitled thereto hereunder and shall maintain, or cause to be maintained, such records and accounts and shall from time to time deliver such reports to employees, participants and government agencies, as shall be required by law or as may otherwise be necessary to show the contributions made by each participant, the separate contributions made by the Company and each subsidiary and affiliate which shall have adopted the Plan.

SECTION 4

ELIGIBILITY

4.1 Life Insurance and Medical Benefits

Each Employee who is not a participant in some other non-government

life and medical plan, the cost of which is borne in full or in part by the Employer, unless he is included in a collective bargaining unit with which the Employer has bargained in good faith with respect to benefits for the Employee which are not covered by the Plan, shall be eligible to become a Participant on the first day of the month after having completed at least one month of continuous service as an Employee. He may also obtain medical benefits under the Plan for his spouse and his dependent children (each child age 18 or under, each child age 22 or under who is a full-time student at an accredited school, and each child of any age who is incapable of self-sustaining employment by

reason of mental retardation or physical handicap).

4.2 Disability Insurance

Each Employee who is not a participant in some other non-government income plan, the cost of which is borne in full or in part by the Employer, unless he is included in a collective bargaining unit with which the Employer has bargained in good faith with respect to benefits for the Employee which are not covered by the Plan, and whose annual earnings from the Employer are at the rate of Ten Thousand Dollars ($10,000) or more, shall be eligible to become a Participant in the disability insurance provisions of the Plan on the first day of the month coincidental with, or following the date of, employment or the

date his rate of annual earnings qualifies him for participation.

SECTION 5

EMPLOYEE CONTRIBUTIONS

A Participant shall make contributions determined by the Plan Administrator on a non-discriminatory basis for all Participants employed by the Employer.

A Participant's contributions shall be made by payroll deductions and no refund of contributions is obtainable as long as he remains a Participant.

A Participant who fails or refuses to make a contribution in any month in which he is eligible to so contribute may resume contributions by making written application on a form provided by the Employer for that purpose and such application shall be approved promptly if the Participant is eligible and his participation shall be effective

the first day of the month following approval of his application by the Employer.

SECTION 6

RIGHTS, DUTIES AND OBLIGATIONS OF INSURER

Any right, duty (including the duty to make payment of any Plan benefits) or obligation reserved to or imposed upon an Insurer under any insurance contract issued by it or other agreement between it and the Company in connection with the Plan is in no way preempted, increased or diminished by virtue of any provision of this Plan and shall remain the sole right, duty or obligation of that Insurer.

SECTION 7

FILING CLAIMS AND REVIEW OF DENIAL OF CLAIM

7.1 Filing of a Claim

Claims for the payment of any benefits provided by this Plan shall be filed in accordance with the insurance contract or other

document pertaining to the benefits in question.

7.2 Notification of Decision

If a claim is wholly or partially denied, notice of the decision shall be furnished to the claimant, within a reasonable period of time after receipt of the claim by the Plan, setting forth:

(a) The specific reason or reasons for the denial;

(b) Specific reference to pertinent Plan provisions on which the denial is based;

(c) A description of any additional material or information necessary for the claimant to perfect the claim, and an explanation of why such material or information is necessary; and

(d) An explanation of the provisions of subsections 7.3 and 7.4 of this Plan.

If notice of the denial of a claim is not furnished, and the claim has not been granted within a reasonable time the claim shall be deemed denied for the purposes of proceeding to the review stage described in subsection 7.3.

7.3 Review Procedure

Following receipt of notice of denial of any claim for a benefit under the Plan, a Participant or Beneficiary (named in accordance with the provisions of any insurance contract or other pertinent document), or the authorized representative thereof, may review the documents underlying such claim and on which the denial was based.

Within sixty days following the date of notice of denial of a claim, a Participant or a Beneficiary or the authorized representative thereof, may, in writing, request a review of such denial by the Named Fiduciary, and may submit written issues and comments to it.

7.4 Decision on Review

Within 10 days of receiving a request for review, the Named Fiduciary shall acknowledge in writing to the person filing the request the receipt thereof and the date of such receipt. The Named Fiduciary shall then review the matter and, after such consultation with the Participant or Beneficiary and Insurer as the Named Fiduciary deems appropriate, shall render a decision to the Participant or

Beneficiary, which decision shall be made not later than 60 days following receipt of the request for review, unless special circumstances require an extension of time for processing, in which case a decision shall be rendered as soon as possible, but not later than 120 days following receipt of the request for review. Except as may be otherwise required by law, the decision of the Named Fiduciary shall be binding on all parties.

SECTION 8

AMENDMENT OR TERMINATION

8.1 Amendment

While the Company expects to continue the Plan, it must necessarily reserve and reserves the right to:

(a) Amend the Plan and, in conjunction with any issuing insurer, amend or replace any insurance contract or other document identified in Section 10, from time to time; and

(b) Revise Plan benefits from time to time under any insurance contract or other document identified in Section 10 or substituted for any such insurance contract or other document.

8.2 Termination

The Company may at any time terminate the Plan or any insurance contract or other document identified in Section 10, or substituted for any such insurance contract, or other document, subject to the

contractual rights of the insurer, if any.

Adopted as amended in the form herein and above set forth by Hart Schaffner & Marx, a New York corporation, as of March 1, 1976.

HART SCHAFFNER & MARX

By_____

Jerome S. Gore, President